ProAssurance

ProNational INSURANCE COMPANY

ProNational Insurance Company

800/282-6242
Fax 205/802-4775

November 11, 2008

Ms. Gayle Neuman
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767

RE: ProNational Insurance Company
FEIN 38-2317569
Company Filing Number IL0109
Health Care Professionals Underwriting Rates and Rules Manual (Physicians, Surgeons, Podiatrists and Allied Health Professionals

Dear Ms. Neuman:

I submit for your review and approval the rate and rule filing for the captioned program. While we are requesting an effective date of January 1, 2009, in the interest of complying with prior notice to be given to insureds, we would appreciate a response as soon as possible.

Please find enclosed Exhibit A regarding the moving of Sangamon County from Territory 4 to Territory 2. Other changes include reducing the legal defense charge from $500 to $100, adding the minimum premium for partnerships, corporations and professional associations to $1,000 and removing all references to dentists and oral surgeons from the manual. Please note that coverage for these insureds will be issued through ProNational's affiliate, Physicians Insurance Company of Wisconsin, whose rates, rules and forms are on file with your department.

If this filing is acceptable, please return one copy of the filing with your stamp of approval in the postage paid envelope that is enclosed for your convenience. If you have any questions regarding this filing, please contact me at (800) 282-6242, ext. 4426, or e-mail me at lgoodwin@proassurance.com.

Sincerely,

LaQuita B. Goodwin
Compliance Specialist

Enclosures

-0.03%

Neuman, Gayle

From: Goodwin, LaQuita [LGoodwin@proassurance.com]
Sent: Monday, June 27, 2011 8:00 AM
To: Neuman, Gayle
Subject: RE: ProAssurance Casualty Company - Filing #IL0109

Ms. Neuman,

The referenced filing was put into effect on January 1, 2009.

Thank you.

LaQuita B. Goodwin
Compliance Specialist, Legal Dept.
ProAssurance Companies
205.877.4426 Direct
205.414.2887 Fax
Birmingham, Alabama

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Friday, June 24, 2011 8:37 AM
To: Goodwin, LaQuita
Subject: Proassurance Casualty Company - Filing #IL0109

Ms. Goodwin,

The Department of Insurance completed its review of the filing referenced above on June 22, 2011. Originally, Proassurance Casualty requested the filing be effective January 1, 2009. Was the filing put into effect on January 1, 2009 or do you wish to have a different effective date?

Your prompt response is appreciated.

Gayle Neuman
Illinois Department of Insurance
Property & Casualty Compliance
(217) 524-6497

Please refer to the Property & Casualty Review Checklists before submitting any filing. The checklists can be accessed through the Department's website at www.insurance.illinois.gov.

Section 754.EXHIBIT A Summary Sheet (Form RF-3)

FORM (RF-3)

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective 1/1/2009.

	(1) Coverage	(2) Annual Premium Volume (Illinois) *	(3) Percent Change (+or-) **
1.	Automobile Liability Private Passenger		
	Commercial		
2	Automobile Physical Damag Private Passenger		
	Commercial		
3.	Liability Other Than Auto		
4.	Burglary and Theft		
5.	Glass		
6.	Fidelity		
7.	Surety		
8.	Boiler and Machinery		
9.	Fire		
10.	Extended Coverage		
11.	Inland Marine		
12.	Homeowners		
13.	Commercial Multi-Peril		
14.	Crop Hail		
15.	Other Medical Malpractice Life of Insurance	19,351,487	-0.03%

Does filing only apply to certain territory (territories) or certain Classes? If so, specify: The territory change only applies to Sangamon county.

Brief description of filing. (If filing follows rates of an advisory Organization, specify organization): Changing territory assignment for Sangamon County, reducing legal defense charge from $500 to $100, adding minimum premium for partnerships, corporations and professional association and removing all references to dentists and oral surgeons from manual

*Adjusted to reflect all prior rate changes.

**Change in Company's premium level which will result from application of new rates.

Physicians, Surgeons, pediatrists, & Allied Health Professionals

ProNational INsurance Company
Name of Company

LaQuita B. Goodwin, Compliance Specialist
Official – Title

filing # IL0109

ILLINOIS CERTIFICATION FOR MEDICAL MALPRACTICE RATES

(215 ILCS 5/155.18)(3) states that medical liability rates shall be certified in such filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

I, Kathryn A. Neville, a duly authorized officer of ProNational Insurance Company, am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing. I also certify that all changes made were disclosed, no written statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.

I, Howard H. Friedman, a duly authorized actuary of ProNational Insurance Company, am authorized to certify on behalf of ProNational Insurance Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

Kathryn A. Neville, Vice President — 11-11-08

Signature and Title of Authorized Insurance Company Officer — Date

Howard H. Friedman, ACAS, MAAA, Senior Vice President — 11/11/08

Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 38-2317569 Filing Number IL0709

Insurer's Address 100 Brookwood Place

City Birmingham State Alabama Zip Code 35209

Contact Person's:

-Name and E-mail LaQuita B. Goodwin, Compliance Specialist – lgoodwin@proassurance.com

-Direct Telephone and Fax Number (205) 877-4426 – Fax (205) 414-2887

Neuman, Gayle

From: Goodwin, LaQuita [LGoodwin@proassurance.com]
Sent: Monday, January 11, 2010 9:56 AM
To: Neuman, Gayle
Subject: RE: ProAssurance Casualty (ProNational) - Filing #IL0109

Yes, we have a plan for gathering statistics. Our stat agency is ISO.

Let me know if you have any other questions or concerns.

Thank you.

LaQuita B. Goodwin
Compliance Specialist, Legal Dept.
ProAssurance Companies
205.877.4426 Direct
205.414.2887 Fax
Birmingham, Alabama

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, January 11, 2010 9:46 AM
To: Goodwin, LaQuita
Subject: ProAssurance Casualty (ProNational) - Filing #IL0109

Ms. Goodwin,
Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If yes, what stat agency is being used? I request your response as soon as possible.

Gayle Neuman
Illinois Department of Insurance
Property & Casualty Compliance
(217) 524-6497

Please refer to the Property & Casualty Review Checklists before submitting any filing. The checklists can be accessed through the Department's website at www.insurance.illinois.gov.

Marked Pages of Manual

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AND ORAL SURGEONS¶
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IV. PART-TIME AND SEMI-RETIRED PHYSICIANS

The Part-Time Discount is available to physicians and surgeons only, Deleted: , not dentists or oral surgeons

A. who have at least 15 years of postgraduate clinical practice experience and are scaling back their practice in anticipation of retirement; or
B. who practice less than 20 hours per week due to family needs (caring for young children and/or ill or disabled family members); or
C. who are required to practice on a reduced basis as a result of a physical or medical condition, with the company's approval; or
D. who practice at least 30 hours per week at a hospital, community health center or other health care facility where medical professional liability insurance is provided by the facility. A certificate of insurance listing the Company as certificate holder must be presented annually for the credit to apply.

Insureds eligible for the New Doctor Discount are not eligible for the Part-Time Discount. Also, physicians employing or supervising paramedicals are not eligible for the Part-Time Discount.

This discount is intended to more accurately rate the insured who practices his specialty on a limited basis. The available discounts are:

TYPE	Class	Average Weekly Practice Hours <20 hours
Physician	1 to 7	50%
Surgeon	8 to 15	35%
All other		None

* Physicians and Surgeons whose average weekly practice hours of less than 12 hours will be individually evaluated by the company.

Practice hours are defined as:

- hospital rounds,
- charting and patient planning,
- on call hours involving patient contact, whether direct or by telephone,
- consultation with other physicians, and
- patient visits/consultations.

Practice hours of physicians receiving the Part-Time Discount are subject to random audit by the Company.

V. LOCUM TENENS

Locum tenens coverage is provided at no additional charge for up to 45 days in any policy year and provides a shared limit with the insured. The locum tenens doctor must submit an application for Company approval in advance of the requested effective date of coverage.

VI. CORPORATE LIABILITY - SHARED LIMIT

No charge will be made for entities sharing in the available limits of liability of the insured physicians or dentists or other insured organizations, providing each member is insured by the Company and the risk is otherwise acceptable.

VII. FULL-TIME EQUIVALENT RATING

Rating of certain multi-physician groups may, at the Company's option, be determined on a full-time equivalent (FTE) unit basis. Under this rating method, policies may be issued to positions with individuals who may fill such positions identified rather than being issued to specific individuals. An FTE rate will be determined based upon the filed and approved rate for a given classification of physicians or surgeons but will be allocated based upon either the number of average hours of practice for a given specialty or the average number of patient contacts/visits in a 12 month period. A risk with fewer than 50,000 patient encounters each year will not qualify for full-time equivalent rating.

All FTE rated applications shall be referred to the Company.

ADDITIONAL PRACTICE CHARGES

I. MEDICAL SERVICES PROVIDED IN A STATE OUTSIDE THE STATE OF POLICY ISSUANCE

Insureds engaging in the routine care and treatment of patients outside the state in which the policy is issued may be subject to appropriate surcharge or credit based upon rates consistent with those charged for a like risk in said state.

II. PARTNERSHIP - CORPORATION - PROFESSIONAL ASSOCIATION COVERAGE

Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. For each member physician not individually insured by the Company, a premium charge will be made equal to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage under the separate policy, the Company must insure all member physicians or at least 60% of the physician members must be insured by the Company and the remaining physicians must be insured by another professional liability program acceptable to the Company.

Number of Insureds	Percent
2 - 5	15.0%
6 - 9	12.0%
10 - 19	9.0%
20 - 49	7.0%
50 or more	5.0%

A separate corporate limit is not available for solo practitioners. The minimum premium for separate limits for partnerships, corporations or professional associations is $1,000.

Deleted: or dentists
Deleted: A
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Deleted: not available to insureds purchasing limits of less than $1M/
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III. PARTNERSHIP–CORPORATION-PROFESSIONAL ASSOCIATION EXTENDED REPORTING ENDORSEMENT COVERAGE

Partnerships, corporations, or professional associations that purchase a separate limit of liability may be eligible to purchase an Extended Reporting Endorsement upon cancellation of the coverage. For the entity to be eligible for the separate limit extended reporting endorsement, all physician members insured on the policy must exercise their right to purchase an individual extended reporting endorsement. The premium charge for the entity extended reporting endorsement will be a percentage of the sum of each member physician's net individual reporting endorsement premium, based on the number of insureds and the table in Paragraph II, above.

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8. Section 5, Additional Practice Charg hereby amended as follows:

V. LEGAL DEFENSE COVERAGE

The Company offers two levels of Professional Legal Defense Coverage to insured physicians. No charge is made for the basic coverage, form PRA-HCP-070. The most comprehensive, form PRA-HCP-071, entails a base premium charge of $100 per insured physician. A volume discount will be given, per the schedule below.

# of Insured Physicians	Discount %
5 and under	0%
6 through 10	5%
11 through 20	10%
over 20	15%

Limits of Liability will be offered as follows:

# of insureds	"Each Covered Investigation"	"Each Policy Period"
1 - 5	$25,000	$25,000 X (# of insureds)
6 - 10	$25,000	$125,000
11 - 20	$25,000	$175,000
21 +	$25,000	$225,000

The limit of liability for "covered audits" will be $5,000 per covered insured with a deductible of $1,000 per audit per insured.

b. For per patient rated risks, [redacted] average number of patient visits for the prev[redacted] thirty-six months. The only credit/discount that applies is the Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.
c. Determine the remaining optional separate limit premium, if applicable.
d. Add premiums determined in Steps a., b. and c. to determine total policy premium.

B. Rating Territories

Territory	County
1	Cook, Madison, St. Clair and Will Counties
2	Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson, Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties
3	Remainder of State
4	DuPage, Kane, Lake and McHenry Counties
5	Jackson and Vermilion Counties

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Pg 56

Contact Person:
Gayle Neuman
217-524-6497
Gayle.Neuman@illinois.gov

Illinois Division of Insurance
Review Requirements Checklist

320 West Washington Street
Springfield, IL 62767-0001

Effective as of 8/25/06

Line(s) of Business	Code(s)	
_X__MEDICAL MALPRACTICE	**11.0000**	***This checklist is for rate/rule
_X__Claims Made	11.10000	**filings only.**
___Occurrence	11.2000	**See separate form checklist.**

Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)
___Acupuncture	11.0001	___Hospitals	11.0009	___Optometry	11.0019
___Ambulance Services	11.0002	___Professional Nurses	11.0032	___Osteopathy	11.0020
___Anesthetist	11.0031	___Nurse – Anesthetists	11.0010	___Pharmacy	11.0021
___Assisted Living Facility	11.0033	___Nurse – Lic. Practical	11.0011	___Physical Therapy	11.0022
___Chiropractic	11.0003	___Nurse – Midwife	11.0012	___Physicians & Surgeons	11.0023
___Community Health Center	11.0004	___Nurse – Practitioners	11.0013	___Physicians Assistants	11.0024
___Dental Hygienists	11.0005	___Nurse – Private Duty	11.0014	___Podiatry	11.0025
___Dentists	11.0030	___Nurse – Registered	11.0015	___Psychiatry	11.0026
___Dentists – General Practice	11.0006	___Nursing Homes	11.0016	___Psychology	11.0027
___Dentists – Oral Surgeon	11.0007	___Occupational Therapy	11.0017	___Speech Pathology	11.0028
___Home Care Service Agencies	11.0008	___Ophthalmic Dispensing	11.0018	___Other	11.0029

Illinois Insurance Code Link	Illinois Compiled Statutes Online	
Illinois Administrative Code Link	Administrative Regulations Online	
Product Coding Matrix Link	Product Coding Matrix	
NAIC Uniform Transmittal Form	50 IL Adm. Code 929 NAIC Uniform Transmittal Form	If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in the "Cover Letter & Explanatory Memorandum" section below are properly included.
NAIC Self-Certification Pilot Program	Newsletter Article regarding Division's Participation Self-Certification form	If an authorized company officer completes the Self-Certification form, and submits such form as the 1st page of the filing, the Division will expedite review of the filing ahead of all other filings received to date. The Division will track company compliance with the laws, regulations, bulletins, and this checklist and report such information to the NAIC.
Location of Standard within Filing Column	See checklist format below.	To expedite review of your filing, use this column to indicate location of the standard within the filing (e.g. page #, section title, etc.)
Description of Review Standards Requirements Column	See checklist format below.	These brief summaries do not include all requirements of all laws, regulations, bulletins, or requirements, so review actual law, regulation, bulletin, or requirement for details to ensure that forms are fully compliant before filing with the Division of Insurance.

FILING REQUIREMENTS FOR FORM FILINGS	REFERENCE	DESCRIPTION OF REQUIREMENT	LOCATION OF STANDARD WITHIN FILING
See separate form filing checklist.		To assist insurers in submitting compliant medical liability rate/rule filings as a result of newly-passed PA94-677 (SB475), the Division has created this separate, comprehensive rate/rule filing checklist for medical liability filings. Please see the separate form filing checklist for requirements related to medical liability forms.	No forms being filed
GENERAL FILING REQUIREMENTS FOR ALL RATE/RULE FILINGS			
LINE OF AUTHORITY			
Must have proper Class and Clause authority to conduct this line of business in Illinois.	215 ILCS 5/4 List of Classes/Clauses	To write Medical Liability insurance in Illinois, companies must be licensed to write: 1. Class 2, Clause (c)	Acknowledged
RATES AND RULES REQUIRED TO BE FILED			
Rates/Rules shall be Filed Separately from Forms			
Insurers shall make separate filings for rate/rules and for forms/endorsements, etc.		The laws and regulations for medical liability forms/endorsements and the laws for medical liability rates/rules are different and each must be reviewed according to its own set of laws/regulations/procedures. Therefore, insurers are required to file forms and rates/rules separately. For requirements regarding form filings, see separate form filing checklist.	No forms being filed
New Insurers			
New insurers must file their rates, rules, plans for gathering statistics, etc. upon commencement of business.	215 ILCS 5/155.18 50 IL Adm. Code 929	"New Insures" are insurers who are: • New to Illinois. • New writers of medical liability insurance in Illinois. • Writing a new Line of Insurance listed on Page 1 of this checklist, New insurers must file the following: a) Medical liability insurance rate manual, including	N/A

		all rates. b) Rules, including underwriting rule manuals which contain rules for applying rates or rating plans, c) Classifications and other such schedules used in writing medical liability insurance. d) Statement regarding whether the insurer: • Has its own plan for the gathering of medical liability statistics; or • Reports its medical liability statistics to a statistical agent (and if so, which agent). The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency. Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.	
Amendments to Initial Rate/Rule Filings			
After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules, or advise of changes to statistical plans, as often as they are amended.	215 ILCS 5/155.18 50 IL Adm. Code 929	After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules/rating schedules (as described above for new business) as often as such filings are changed or amended, or when any new rates or rules are added. Any change in premium to the company's insureds as a result of a change in the company's base rates or a change in its increased limits factors shall constitute a change in rates and shall require a filing with the Director. Insurers shall also advise the Director if its plans for the gathering of statistics has changed, or if the insurer has changed statistical agents. The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency. Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.	N/A
EFFECTIVE DATES OF			

RATE/RULE FILINGS			
Illinois is "file and use" for medical liability rates and rules.	215 ILCS 5/155.18 50 IL Adm. Code 929	A rate/rating plan/rule filing shall go into effect no earlier than the date the filing is received by the Division of Insurance, Property & Casualty Compliance Section, except as otherwise provided in Section 155.18.	Effective 1/1/2009
ADOPTIONS OF ADVISORY ORGANIZATION FILINGS			
Insurer must file all rates and rules on its own behalf.	50 IL Adm. Code 929	Although Rule 929 allows for insurers to adopt advisory organization rule filings, advisory organizations no longer file rules in Illinois.	N/A
COPIES, RETURN ENVELOPES, ETC.			
Requirement for duplicate copies and return envelope with adequate postage.	50 IL Adm. Code 929	Insurers that desire a stamped returned copy of the filing or submission letter must submit a duplicate copy of the filing/letter, along with a return envelope large enough and containing enough postage to accommodate the return filing.	Included
COVER LETTER & EXPLANATORY MEMORANDUM			
Two copies of a submission letter are required, and the submission letter must contain the information specified. "Me too" filings are not allowed. Use of NAIC Uniform Transmittal form is acceptable as long as all required information is included.	215 ILCS 5/155.18 50 IL Adm. Code 929 Company Bulletin 88-53 Actuarial Certification Form NAIC Uniform Transmittal Form	All filings must be accompanied by a submission letter which includes all of the following information: 1) Exact name of the company making the filing. 2) Federal Employer Identification Number (FEIN) of the company making the filing. 3) Unique filing identification number – may be alpha, numeric, or both. Each filing number must be unique within a company and may not be repeated on subsequent filings. If filing subsequent revisions to a pending filing, use the same filing number as the pending filing or the revision(s) will be considered a new filing. 4) Identification of the classes of medical liability insurance to which the filing applies (for identifying classes, refer to Lines of Insurance shown on Page 1 of this checklist, in compliance with the NAIC Product Coding Matrix). 5) Notification of whether the filing is new or supersedes a present filing. If filing supersedes a present filing, insurer must identify all changes in superseding filings, and all superseded filings, including the following information: • Copy of the complete rate/rule manual section(s) being changed by the filing with all changes clearly highlighted or otherwise identified. • Written statement that all changes made to the superseded filing have been disclosed. • List of all pages that are being completely	Acknowledged See Cover Letter and NAIC Transmittal

		superseded or replaced with new pages. • List of pages that are being withdrawn and not being replaced. • List of new pages that are being added to the superseded filing. • Copies of all manual pages that are affected by the new filing, including but not limited to subsequent pages that are amended solely by receiving new page numbers. 6) Effective date of use. 7) Actuarial certification (see Actuarial Certification section below). Insurers may use their own form or may use the sample form developed by the Division. 8) Statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate. Companies under the same ownership or general management are required to make separate, individual company filings. Company Group ("Me too") filings are unacceptable. If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in this section is properly included.	
FORM RF-3 Summary Sheet			
For any rate change, duplicate copies of Form RF-3 must be filed, no later than the effective date.	50 IL Adm. Code 929 Form RF-3 Summary Sheet	For any rate level change, insurers must file two copies of Form RF-3 (Summary Sheet) which provides information on changes in rate level based on the company's premium volume, rating system, and distribution of business with respect to the classes of medical liability insurance to which the rate revision applies. Such forms must be received by the Division's Property & Casualty Compliance Section no later than the stated effective date of use. Insurers must report the rate change level and premium volume amounts on the "Other" Line and insert the words "Medical Liability" on the "Other" descriptive line. Do not list the information on the "Other Liability" line. If the Medical Liability premium is combined with any other Lines of Business (e.g. CGL, commercial property, etc.), the insurer must report the effect of rate changes to each line separately on the RF-3, indicating the premium written and percent of rate change for each line of business. The RF-3 form must indicate whether the information is "exact" or "estimated."	Included
PAYMENT PLANS			

Quarterly premium payment installment plan required as prescribed by the Director.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois shall offer to each of its medical liability insureds the option to make premium payments in quarterly installments as prescribed by and filed with the Director. Such option must be offered in the initial offer of the policy or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer need not offer the option, but if the insured requests it, must make it available. Such plans are subject to the following minimum requirements: • May not require more than 40% of the estimated total premium to be paid as the initial payment; • Must spread the remaining premium equally among the 2nd, 3rd, and 4th installments, with the maximum set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively; • May not apply interest charges; • May include an installment charge or fee of no more than the lesser of 1% of the total premium or $25; • Must spread any additional premium resulting from changes to the policy equally over the remaining installments, if any. If there are no remaining installments, the additional premium may be billed immediately as a separate transaction; and • May, but is not required to offer payment plan for extensions of a reporting period, or to insureds whose annual premiums are less than $500. However, if offered to either, the plan must be made available to all within that group.	52, 59 and 66
DEDUCTIBLES			
Deductible plans should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer the opportunity for participation in a plan offering deductibles to its medical liability insureds. Any such plan shall be contained in a filed rate/rule manual section entitled "Deductibles Offered" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the section that applies.	49 and 50
DISCOUNTS			

Premium discount for risk management activities should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer their medical liability insureds a plan providing premium discounts for participation in risk management activities. Any such plan shall be contained in a filed rate/rule manual section entitled "Risk Management Activities Discounts" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the section that applies.	15 and 16
CLAIMS MADE REQUIREMENTS			
Extended reporting period (tail coverage) requirements.	215 ILCS 5/143(2) Company Bulletin 88-50	When issuing claims-made medical liability insurance policies, insurers must include the following specific information in their rate/rule manuals: • Offer of an extended reporting period (tail coverage) of at least 12 months. The rate/rule manual must specify whether the extended reporting period is unlimited or indicate its term (i.e. number of years).*** • Cost of the extended reporting period, which must be priced as a factor of one of the following:*** o the last 12 months' premium. o the premium in effect at policy issuance. o the expiring annual premium. • List of any credits, discounts, etc. that will be added or removed when determining the final extended reporting period premium. • Insurer will inform the insured of the extended reporting period premium at the time the last policy is purchased. The insurer may not wait until the insured requests to purchase the extended reporting period coverage to tell the insured what the premium will be or how the premium would be calculated. • Insurer will offer the extended reporting period when the policy is terminated for any reason, including non-payment of premium, and whether the policy is terminated at the company's or insured's request. • Insurer will allow the insured 30 days after the policy is terminated to purchase the extended reporting period coverage.*** • Insurer will trigger the claims made coverage when notice of claim is received and recorded by the insured or company, whichever comes first.	13, 47, 53, 55, 56, 57, 61, 65 Also, see PRA-HCP-606 that was approved by Illinois Department of Insurance

		***If the medical liability coverage is combined with other professional or general liability coverages, the medical liability insurer must meet all of the above requirements, except those indicated with ***, in which case, the insurer must: • Offer free 5-year extended reporting period (tail coverage) or • Offer an unlimited extended reporting period with the limits reinstated (100% of aggregate expiring limits for the duration) • Cap the premium at 200% of the annual premium of the expiring policy; and • Give the insured a free-60 day period after the end of the policy to request the coverage.	
GROUP MEDICAL LIABILITY			
Group medical liability insurance is not specifically allowed under the Illinois Insurance Code.	50 IL Adm. Code 906	Part 906 of the Illinois Administrative Code prohibits writing of group casualty (liability) insurance unless specifically authorized by statute. The Illinois Insurance Code does not specifically authorize the writing of group medical liability insurance.	N/A
CANCELLATION & NONRENEWAL PROVISION REQUIREMENTS			
If rate/rule manuals contain language pertaining to cancellation or nonrenewal, must comply with all cancellation/nonrenewal laws.	See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	If a rate or rule manual contains language pertaining to cancellation or nonrenewal of any medical liability insurance coverage, such provisions must comply with all cancellation and nonrenewal provisions of the Illinois Insurance Code, including but not limited to the following: 143.10, 143.16, 143.16a, 143.17a. See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	Page 4 Also, see PRA-HCP-606 that was approved by Illinois Department of Insurance
ACTUARIAL REVIEW REQUIREMENTS			
Rates shall not be excessive, inadequate, or unfairly discriminatory.	215 ILCS 5/155.18	In the making or use of rates pertaining to all classes of medical liability insurance, rates shall not be excessive, or inadequate, nor shall they be unfairly discriminatory. Rate and rule manual provisions should be defined and explained in a manner that allows the Division to ascertain whether the provision could be applied in an unfairly discriminatory manner. For example, if a rate/rule manual contains ranges of premiums or discounts, the provision must specify the criteria to determine the specific premium/discount an insured or applicant would receive. The Director may, by order, adjust a rate or take any other appropriate action at the conclusion of a public hearing.	See Filing Memorandum and its Exhibits
PRICING			

Insurers shall consider certain information when developing medical liability rates.	215 ILCS 5/155.18	Consideration shall be given, to the extent applicable, to past and prospective loss experience within and outside this State, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both countrywide and those especially applicable to Illinois, and to all other factors, including judgment factors, deemed relevant within and outside Illinois. Consideration may also be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by companies to their policyholders, members or subscribers. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	N/A – We believe this is not required because we are not making a true rate filing
Minimum Premium Rules			
Insurers may group or classify risks for establishing rates and minimum premiums.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	Page 4, 21, 52
"A" RATED RISKS			
Individual Risk Rating			
Risks may be rated on an individual basis as long as all provisions required in Section 155.18 are met.	215 ILCS 5/155.18	Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Such classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations, and shall apply to all risks under the same or substantially the same circumstances or conditions. The rate for an established classification should be related generally to the anticipated loss and expense factors or the class.	Page 4
RISK CLASSIFICATION			
Risks may be grouped by classifications.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	30
Rating decisions based solely on domestic violence.	215 ILCS 5/155.22b	No insurer may that issues a property and casualty policy may use the fact that an applicant or insured incurred bodily injury as a result of a battery committed against him/her by a spouse or person in the same household as a sole reason for a rating decision.	N/A
Unfair methods of	215 ILCS 5/424(3)	It is an unfair method of competition or unfair and	

competition or unfair or deceptive acts or practices defined.		deceptive act or practice if a company makes or permits any unfair discrimination between individuals or risks of the same class or of essentially the same hazard and expense element because of the race, color, religion, or national origin of such insurance risks or applicants.	Acknowledged
Procedure as to unfair methods of competition or unfair or deceptive acts or practices not defined.	215 ILCS 5/429	Outlines the procedures the Director follows when he has reason to believe that a company is engaging in unfair methods of competition or unfair or deceptive acts or practices.	Acknowledged
Territorial Definitions			
Rate/rule manuals must contain correct and adequate definitions of Illinois territories.	215 ILCS 5/155.18	When an insurer's rate/rule program includes differing territories within the State of Illinois, rate/rule manuals must contain correct and adequate definitions of those territories, and that all references to the territories or definitions are accurate, so the Division does not need to request additional information.	31-39 and 56
ACTUARIAL SUPPORT INFORMATION REQUIRED			
ACTUARIAL CERTIFICATION			
Actuarial certification must accompany all rate filings and all rule filings that affect rates.	215 ILCS 5/155.18 50 IL Adm. Code 929 Actuarial Certification Form	Every rate and/or rating rule filing must include a certification by an officer of the company and a qualified actuary that the company's rates and/or rules are based on sound actuarial principles and are not inconsistent with the company's experience. Insurers may use their own form or may use the sample form created by the Division.	Included
ACTUARIAL OR STATISTICAL INFORMATION			
Director may request actuarial and statistical information.	215 ILCS 5/155.18 50 IL Adm. Code 929	The Director may require the filing of statistical data and any other pertinent information necessary to determine the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, rates, forms or any combination thereof. If the Director requests information or statistical data to determine the manner the insurer used to set the filed rates and/or to determine the reasonableness of those rates, as well as the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, or any combination thereof, the insurer shall provide such data or information within 14 calendar days of the Director's request.	Acknowledged
Explanatory			

Memorandum			
Insurers shall include actuarial explanatory memorandum with any rate filing, as well as any rule filing that affects the ultimate premium.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial explanatory memorandum with any rate filing, as well as any rule filing that affects the ultimate premium. The explanatory memorandum shall contain, at minimum, the following information: • Explanation of ratemaking methodologies. • Explanations of specific changes included in the filing. • Narrative that will assist in understanding the filing.	N/A
Summary of Effects Exhibit			
Insurers shall include an exhibit illustrating the effect of each change and calculation indicating how the final effect was derived.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the effect of each individual change being made in the filing (e.g. territorial base rates, classification factor changes, number of exposures affected by each change being made, etc.), and include a supporting calculation indicating how the final effect was derived.	Exhibit A
Actuarial Indication			
Insurers shall include actuarial support justifying the overall changes being made.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support justifying the overall changes being made, including but not limited to: • Pure premiums (if used). • Earned premiums. • Incurred losses. • Loss development factors. • Trend factors. • On-Level factors. • Permissible loss ratios, etc.	N/A
Loss Development Factors and Analysis			
Insurers shall include support for loss development factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support for loss development factors and analysis, including but not limited to loss triangles and selected factors, as well as support for the selected factors.	N/A
Ultimate Loss Selections			
Insurers shall include support for ultimate loss selections.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for ultimate loss selections, including an explanation of selected losses if results from various methods differ significantly.	N/A
Trend Factors and Analysis			
Insurers shall include support for trend factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for trend factors and analysis, including loss and premium trend exhibits demonstrating the basis for the selections used.	N/A
On-Level Factors and			

Analysis			
Insurers shall include support for on-level factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for on-level factors and analysis, including exhibits providing on-level factors and past rate changes included in calculations.	N/A
Loss Adjustment Expenses			
Insurers shall include support for loss adjustment expenses.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for loss adjustment expenses, including exhibits providing documentation to support factors used for ALAE and ULAE. If ALAE is included in loss development analysis, no additional ALAE exhibit is required.	N/A
Expense Exhibit			
Insurers shall include an expense exhibit. Insurers may use expense provisions that differ from those of other companies or groups of companies.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit indicating all expenses used in the calculation of the permissible loss ratio, including explanations and support for selections. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	N/A
Investment Income Calculation			
Insurers shall include an exhibit for investment income calculation.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit demonstrating the calculation for the investment income factor used in the indication.	N/A
Profit and Contingencies Calculation			
Insurers shall include an exhibit for profit and contingencies load.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the derivation of any profit and contingencies load.	N/A
Credibility Standard Used			
Insurers shall include the number of claims being used to calculate the credibility factor.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include the number of claims being used to calculate the credibility factor. If another method of calculating credibility is utilized, insurers should include a description of the method used.	N/A
Other Actuarial Information Required			
Insurers must include the information described in this section.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall also include the following information: • All actuarial support/justification for all rates being changed, including but not limited to changes in: o Base rates; o Territory definitions; o Territory factor changes; o Classification factor changes;	Exhibit A

		○ Classification definition changes; ○ Changes to schedule credits/debits, etc. • Exhibits containing current and proposed rates/factors for all rates and classification factors, etc. being changed. • Any exhibits necessary to support the filing that are not mentioned elsewhere in this checklist.	
Schedule Rating			
Insurers must include the described information described at right.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include appropriate actuarial justification when filing schedule rating plans and/or changes to schedule rating plans.	Page 48

ILLINOIS MANUAL

HEALTH CARE PROFESSIONALS

UNDERWRITING RULES AND RATES

ProAssurance®

ProNational
INSURANCE COMPANY

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SECTION 1

INTRODUCTION

INTRODUCTION

This manual contains the classifications and rates governing the underwriting of Physicians', Surgeons', Dentists', Podiatrists', Allied Health Professionals' and Groups' Professional Liability Insurance by ProNational Insurance Company, hereinafter referred to as "the Company."

I. RATES AND PREMIUM CALCULATIONS

A. Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being $500 (not applicable to paramedicals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3., VIII, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3, VIII, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.

B. Refer to the Company for: Agents should refer to the Company any risk meeting one of the following criteria: a) Any risk or exposure for which there is no manual rate or applicable classification, or b) Risks developing annualized premium of $100,000 or more for basic limits for individual (a) rating.

C. Non-Standard Risks: Individuals rejected for standard coverage by the Company may be individually considered for coverage at an additional premium charge or other applicable coverage conditions and limitations on an individually agreed, consent-to-rate basis.

D. Whole Dollar Premium Rule: The premiums appearing in the State Rates and Exceptions Section of this manual have been rounded to the nearest whole dollar. This procedure shall also apply to all interim premium adjustments, including endorsements or cancellations. A premium involving $.50 or over, shall be rounded to the next higher whole dollar.

II. CANCELLATIONS

Cancellations shall be made only within the parameters established by the State of policy issuance as framed in the Cancellation provisions of the policy including any State-specific endorsement thereto.

A. By the Company: The earned premium shall be determined on a "pro rata" basis.

B. By the Insured: The earned premium shall be determined on a "short rate" basis.

C. Removal from the State: Subject to state provisions, the policy may be canceled by the Company after the insured no longer maintains at least 75% of his medical practice within the state of issuance, regardless of whether notice has been given by the insured.

SECTION 2

PHYSICIANS & SURGEONS SPECIALTY CODES

AND DESCRIPTIONS

Column Heading Definitions

No Surgery: General practitioners and specialists who do not perform surgery or assist in surgery. Incision of boils and superficial abscesses and suturing of skin and superficial fascia are not considered surgery.

Minor Surgery: General practitioners and specialists who perform minor surgery or invasive procedures for diagnostic purposes, or who assist in major surgery on their own patients.

Major Surgery: General practitioners and specialists who perform major surgery on their own patients, or who assist in major surgery on patients of others.

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

* *

Specialty	Industry Class Code No Surgery	Minor Surgery	All Other Surgery
Administrative Medicine	80178	-	-
Allergy	80254	-	-
Anesthesiology	-	-	80151
Bariatrics	-	-	80476
Cardiovascular Disease	80255 -	80281(A) 80281(B)-specified procedures	80150
Colon & Rectal	-	-	80115
Dermatopathology	-	80474	-
Dermatology	80256(A)	80282	80472
Dermatology This classification applies to any dermatologist who performs the following procedures: a) excision of skin lesions with graft or flap repair; b) collagen injections.	80256(B)	-	-
Emergency Medicine This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital or rescue facility.	-	80102(C)	-
Emergency Medicine - Moonlighting (Refer to Classification and/or Rating Modifications & Procedures Section)	80102(A)	80102(B)	

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

* *

Specialty	Industry Class Code: No Surgery	Minor Surgery	All Other Surgery
Family Practitioner or General Practitioner - Limited Obstetrics	-	-	80117(B)
Family Practitioner or General Practitioner – Significant Obstetrics	-	-	80117(C)
Family Practitioner or General Practitioner - No Obstetrics	80420 - -	80421(A)* 80421(B)* 80421(C)*	80117(A) - -
Forensic/Legal Medicine	80240	-	-
Gastroenterology	80241	80274	-
General – N.O.C. This classification does not apply to any family or general practitioners or specialists who occasionally perform surgery.	-	-	80143
General Preventive Medicine	80231	-	-
Gynecology	80244	80277	80167
Hand	-	-	80169
Hematology	80245	80278	-
Hospitalist	-	80222(A) 80222(B)	-
Intensive Care Medicine	-	80283	-
Internal Medicine	80257	80284	-
Nephrology	80260	80287	-
Neurology	80261	80288	80152
Obstetrics/Gynecology	-	-	80153
Occupational Medicine	80233	-	-
Oncology	80473	80286	-
Ophthalmology	80263	80289	80114
Orthopedic – No Spinal Surgery	-	-	80154(A)
Orthopedic – Including Spinal Surgery	-	-	80154(B)

*refer to Classification and/or Rating Modifications & Procedures Section for further definition

PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

* *

Specialty	Industry Class Code No Surgery	Minor Surgery	All Other Surgery
Otorhinolaryngology	80265	80291	80159
Otorhinolaryngology – Including Plastic	-	-	80155
Pain Management	80475(A)	-	80475(B)-basic procedures
	-	-	80475(C)-intermediate procedures
	-	-	80475(D)-advanced procedures
Pathology	80266	-	-
Pediatrics	80267	80293**	-
Physical Medicine & Rehabilitation	80235	-	-
Physicians - N.O.C.	80268	80294	-
Plastic	-	-	80156
Podiatrist	80620	-	80621
Psychiatry	80249	-	-
Psychiatry Including Shock Therapy	80431	-	-
Public Health	80236	-	-
Pulmonary Diseases	80269	***	-
Radiology - Diagnostic	80253	80280	-
Radiology - Including Radiation Therapy	-	80425	-
Radiology – Interventional	-	80360	-
Rheumatology	80252	-	-
Semi-Retired Physicians (Refer to Classification and/or Rating Modifications and Procedures Section.)	80179	-	-
Thoracic	-	-	80144
Traumatic	-	-	80171
Urgent Care (Non-ER, no surgery)	80424(F)	-	-
Urology	80145(A)	80145(B)	80145(C)
Vascular	-	-	80146

**For rating purposes, include Neonatology in this risk class.
***See Internal Medicine – Minor Surgery.

SECTION 3

CLASSIFICATION AND/OR RATING MODIFICATIONS

AND PROCEDURES

CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

I. "MOONLIGHTING" PHYSICIANS

Physicians and surgeons who perform covered "moonlighting" activities may be eligible to be insured at 50% of the rate applicable to the specialty in which the physician or surgeon is "moonlighting."

Covered "moonlighting" activities include:

A. Physicians and surgeons in active, full-time military service requesting coverage for outside activities.

B. Full-time Federal Government employed physicians and surgeons (such as V.A. Hospital employees) requesting coverage for outside activities.

C. Physicians and surgeons employed full-time by the State or County Health Department requesting coverage for outside activities.

D. Residents or fellows currently attending their training program who are requesting coverage for outside activities but only while they are enrolled in such program.

II. FELLOWS, RESIDENTS AND INTERNS

A. Coverage may be written for fellows, residents and interns practicing within the scope of their training in the teaching environment. Clinical exposure must not exceed 30 hours per week. The rate shall generally be 50% of the appropriate specialty classification, but may vary from 25% to 75% depending upon the clinical exposure of each individual rated.

B. If fellows, residents and interns wish to practice outside their training program 100 hours or less per month, coverage may be written at a rate equal to 50% of the appropriate specialty classification. (HOWEVER, the appropriate rate for Emergency Room Moonlighting is equal to 50% of the premium assigned to Class Code 80102(A).

C. Residents who continue to practice in the Emergency Room (part-time or full-time) during an interruption in their training for a period of time not to exceed one year, may qualify for the premium assigned to Class Code 80102(B) if they have no other clinical activities.

III. FAMILY PRACTICE / GENERAL PRACTICE - MINOR SURGERY

Those Family Practice/General Practice Physicians who perform minor surgery procedures and/or assist in surgery on their own or other than their own patients will be classified as follows:

Classification	Rating Criteria:
80421(A)	Assist in major surgery on their own patients only (do not also perform minor surgical procedures).
80421(B)	Perform minor surgical procedures (may also assist in major surgery on their own patients).
80421(C)	Assist in major surgery on the patients of others (may also perform minor surgical procedures and/or assist in major surgery on their own patients).

IV. PART-TIME AND SEMI-RETIRED PHYSICIANS

The Part-Time Discount is available to physicians and surgeons only.

A. who have at least 15 years of postgraduate clinical practice experience and are scaling back their practice in anticipation of retirement; or
B. who practice less than 20 hours per week due to family needs (caring for young children and/or ill or disabled family members); or
C. who are required to practice on a reduced basis as a result of a physical or medical condition, with the company's approval; or
D. who practice at least 30 hours per week at a hospital, community health center or other health care facility where medical professional liability insurance is provided by the facility. A certificate of insurance listing the Company as certificate holder must be presented annually for the credit to apply.

Insureds eligible for the New Doctor Discount are not eligible for the Part-Time Discount. Also, physicians employing or supervising paramedicals are not eligible for the Part-Time Discount.

This discount is intended to more accurately rate the insured who practices his specialty on a limited basis. The available discounts are:

		Average Weekly Practice
TYPE	**Class**	**Hours <20 hours**
Physician	1 to 7	50%
Surgeon	8 to 15	35%
All other		None

* Physicians and Surgeons whose average weekly practice hours of less than 12 hours will be individually evaluated by the company.

Practice hours are defined as:

- hospital rounds,
- charting and patient planning,
- on call hours involving patient contact, whether direct or by telephone,
- consultation with other physicians, and
- patient visits/consultations.

Practice hours of physicians receiving the Part-Time Discount are subject to random audit by the Company.

V. LOCUM TENENS

Locum tenens coverage is provided at no additional charge for up to 45 days in any policy year and provides a shared limit with the insured. The locum tenens doctor must submit an application for Company approval in advance of the requested effective date of coverage.

VI. CORPORATE LIABILITY - SHARED LIMIT

No charge will be made for entities sharing in the available limits of liability of the insured physicians or dentists or other insured organizations, providing each member is insured by the Company and the risk is otherwise acceptable.

VII. FULL-TIME EQUIVALENT RATING

Rating of certain multi-physician groups may, at the Company's option, be determined on a full-time equivalent (FTE) unit basis. Under this rating method, policies may be issued to positions with individuals who may fill such positions identified rather than being issued to specific individuals. An FTE rate will be determined based upon the filed and approved rate for a given classification of physicians or surgeons but will be allocated based upon either the number of average hours of practice for a given specialty or the average number of patient contacts/visits in a 12 month period. A risk with fewer than 50,000 patient encounters each year will not qualify for full-time equivalent rating.

All FTE rated applications shall be referred to the Company.

VIII. RATE ADJUSTMENTS FOR CHANGES IN EXPOSURE -- CLAIMS-MADE, RETROACTIVE, AND REPORTING ENDORSEMENT COVERAGE

A. Claims-Made Coverage

The calculations for changes in exposure are performed by taking the difference between claims-made rates for each period of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used. This method can be generalized by using the following formula to calculate a rate for the upcoming year.

1. Rate for current practice, determined using a retroactive date equal to the date that the *current* practice patterns began,

2. plus rate for prior practice, determined using a retroactive date equal to the date that the *previous* practice patterns began,

3. less rate for prior practice, determined using a retroactive date equal to the date that the *current* practice patterns began.

This method is applied in a similar manner if more than one practice change occurred during the previous four years, and the components are pro-rated if the change occurred at a date other than the policy anniversary date.

For example, if a physician had practiced obstetrics and gynecology for many years, then stopped practicing obstetrics and began to practice gynecology only, the appropriate premium for the upcoming policy period would be:

Gynecology rate for claims-made year one,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year one.

This produces a blended rate, reflecting the remaining OB/GYN exposure that makes up the majority of the expected reported claims in the upcoming year, plus the initial gynecology exposure.

The rate for the second year of gynecology-only practice would be:

Gynecology rate for claims-made year two,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year two.

This adjustment process continues for two more years, until the beginning of the fifth year in the new specialty. At that time, the blended rate would be:

Gynecology rate for claims-made year five,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year five,

which is simply equal to the gynecology rate for claims-made year five.

Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads, additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

B. Prior Acts Coverage

When prior acts coverage is provided, the same method is utilized, as if the insured had been with the Company during the prior acts period. Practice information regarding the prior acts period is obtained from the insurance application.

C. Reporting Endorsement Coverage

If reporting endorsement coverage is to be rated, the same method is utilized, substituting the reporting endorsement rates for the claims-made rates. For example, a reporting endorsement purchased at the end of the second year of gynecology practice in the obstetrics/gynecology example described above would be:

Gynecology reporting endorsement premium for claims-made year two,
plus OB/GYN reporting endorsement premium for claims-made year five,
less OB/GYN reporting endorsement premium for claims-made year two.

IX. REPORTING ENDORSEMENTS (Claims-made only)

A. Reporting Endorsement Premium Calculation

With respect to calculation of Reporting Endorsement premium, the only credits/discounts that apply are the Part-Time Discount and Deductibles credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. With respect to risks or exposures written on a consent-to-rate basis, (a) rated basis or Full-Time Equivalent Rating basis at the time the Reporting Endorsement is issued, Reporting Endorsement premium will be calculated on that same basis. If the policy is terminated during the first year, pro-rate the tail premium. For terminations during the second, third or fourth claims-made policy year, blend the applicable tail factors. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

B. Waiver of Reporting Endorsement Premium

The premium for the reporting endorsement may be waived as provided by the contract in force or at the discretion of the Company.

X. RATE CHANGE AMELIORATION

In situations where a rate change affects a single specialty by greater than 30%, a credit up to 25% may be applied to the new premium for an affected insured to lessen the single year impact of such a significant increase if, based on the underwriter's evaluation of the quality of the risk, such consideration is warranted. The underwriter will consider training and experience, longevity with the company, practice situation and claims history when making any such recommendation. Management approval is required.

SECTION 4

PROFESSIONAL LIABILITY DISCOUNTS

PROFESSIONAL LIABILITY DISCOUNTS

I. MAXIMUM CREDIT

Maximum credit available per insured will be limited to 40% except for the following:

- Part-time exposure rating: up to 50%. Deductible credits and attendance of a ProAssurance Loss Prevention Seminar credit may be combined with the part-time credit but no other credits or discounts apply.
- New doctor discounts: up to 50%. Deductible credits may be combined with the New Doctor discount but no other credits or discounts apply.
- Deductibles/Self-Insured Retentions
- Risks developing $100,000 or more annualized premium

II. NEW DOCTOR DISCOUNT

This discount will apply only to solo practicing physicians who have never been in practice and proceed directly into practice from training, or physicians who fit within that category except for an interim period of employment not to exceed two years. Physicians who would otherwise qualify but who are joining an established group practice insured by the Company where their clinical exposure will not exceed 30 hours per week are to be submitted to the Company for rating.

Year of Coverage Since Training	Annual Premium Discount Per Policy
Year 1	50%
Year 2	25%
Year 3	0%

III. RISK MANAGEMENT PREMIUM CREDITS

Insureds who participate in risk management activities approved by the Company are eligible for the following premium credits, up to a maximum of 10%.

A. Individual Risk Management Activities: Individual insureds may receive premium credits as indicated for completion, within the 12 months prior to application, of the following activities:

	Activity	Credit
1.	Successful completion of an approved fee-for-service office analysis and education program Positive response to recommendations made may result in the application of this credit for up to three policy years. Applicable only to accounts generating $250,000 or more in annual premium.	0% - 5%
2. a.	A Company sponsored Loss Prevention or other approved risk management seminar carrying at least two CME credits (annual); and/or,	0% - 5%

b. an approved closed claim review (annual); and/or — 0% - 5%

c. successful completion of an approved risk management correspondence course carrying at least two CME credits (annual). — 0% - 5%

3. Demonstrated regular use of an approved patient information system or program. — 0% - 5%

Educational activities must qualify for Continuing Medical Education credit (where applicable) to be acceptable for risk management credits. The applicant must provide proof (Certificate) of CME credits earned at the time of application. Activities submitted for risk management credits must have been completed within twelve months prior to application.

B. In addition to the above, any physician or surgeon whose practice benefits from the risk management activities of an employed practice administrator or risk manager may receive one of the following credits:

1. If the practice employs a full-time, qualified, professional risk manager primarily engaged in risk management and loss prevention activities, each insured may receive up to a 5% credit.

2. If the practice administrator or office manager participates in a Company-sponsored Loss Prevention or other risk management seminar, each insured may receive a 2% credit. Certain requirements apply:
   a. The seminar must be designated by the Company as eligible for practice administrator credit.
   b. Attendance must occur within the twelve months prior to application.
   c. At least 75% of the insureds in the practice must qualify for risk management credit as a result of individual risk management activities under the terms of Section III (A)(2), above.
   d. The practice administrator or office manager must actively manage the practice for thirty or more hours per week. In the case of shared practice management, determination of eligibility will rest with the Company.

C. Any risk management credit may be revoked or withheld for any of the following reasons:

1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application.

2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company,

3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or

4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.

5. Negative claim history.

Information obtained in the process of handling a claim may be used in evaluating an insured with respect to the above condition; however, the filing of a claim or incurring any expense or indemnity on behalf of an insured shall not alone be considered grounds for reducing, revoking or withholding a credit.

IV. HOSPITAL BASED DISCOUNT PROGRAMS

A. Advanced Obstetrical Risk Management Program

Obstetrical services may be targeted with a special Advanced Obstetrical Risk Management Program relating to all phases of obstetrical services in both the physician's office or clinic and in the hospital including, but not limited to, intrapartum fetal surveillance, induction and augmentation of labor, emergency cesarean section times, documentation, and anesthesia. The physician must actively participate in the program in order to receive a discount of up to 10%.

No combination of Risk Management and Advanced Obstetrical Risk Management credits shall exceed 20%.

B. Any hospital based discount may be revoked or withheld for any of the following reasons:

1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application.

2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company.

3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or

4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.

5. Negative claim history.

V. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by physicians and surgeons engaged in the practice of medicine. Exposure conditions vary with respect to:

1. Number of years experience in medicine;
2. Number of patient exposures;
3. Organization (if any) and size;
4. Medical standards review and claims review committees;
5. Other risk management practices and procedures;
6. Training, accreditation and credentialing;
7. Continuing Medical Education activities;
8. Professional liability claim experience;
9. Record-keeping practices;
10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;
11. Participation in capitation contracts; and*
12. Insured group maintains differing limits of liability on members.*

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more physicians as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

* NOTE: No credit will be given for #11 or #12 above.

VI. DEDUCTIBLES

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer ($1M/$3M). Deductibles are subject to approval by the company based on financial statements to be submitted by the insured and financial guarantees as required. The company reserves the right to require acceptable securitization in the amount of the per claim and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.

A. Individual Deductibles

See State Rates and Exceptions.

B. Group Deductibles

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

See State Rates and Exceptions.

C. Self-Insured Retentions

Insureds may self-insure a portion of their professional and general liability risk with the Company's policy attaching in excess of the Self-Insured Retention selected. The Self-Insured Retention limit may include ALAE, or ALAE may be paid pro rata. All such policies must be referred to the Company for special consideration.

VII. GENERAL RULES

A. Discounts will only be applied to qualifying insureds at the initial issuance of such policy or at the next renewal date.

B. Discounts will apply in the following order:

1. Deductible Discount (primary premium only).
2. New Doctor Discount or other resident or part-time, semi-retired discount;
3. Risk Management Discount and Scheduled Rating (apply the net credit or debit); and

Example: Class 1, $1M/$3M, 1st year new doctor, Risk Management Seminar within 12 months. $25,000 deductible. Assume manual rate $7,500.

$7,500	Manual Rate for $1M/$3M
x .91	Less 9% (Deductible Credit)
6825	
x .50	Less 50% (New Doctor)
3,413	Applicable Net Premium
x .85	Less 15% (Risk Management Programs, Scheduled Rating)
2,901	Net Premium

C. Additional practice charges will be applied to the premium after all discounts have been applied.

D. Corporate Liability premium will be determined after all discounts and surcharges have been applied.

SECTION 5

ADDITIONAL PRACTICE CHARGES

ADDITIONAL PRACTICE CHARGES

I. MEDICAL SERVICES PROVIDED IN A STATE OUTSIDE THE STATE OF POLICY ISSUANCE

Insureds engaging in the routine care and treatment of patients outside the state in which the policy is issued may be subject to appropriate surcharge or credit based upon rates consistent with those charged for a like risk in said state.

II. PARTNERSHIP - CORPORATION - PROFESSIONAL ASSOCIATION COVERAGE

Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. For each member physician not individually insured by the Company, a premium charge will be made equal to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage under the separate policy, the Company must insure all member physicians or at least 60% of the physician members must be insured by the Company and the remaining physicians must be insured by another professional liability program acceptable to the Company.

Number of Insureds	Percent
2 - 5	15.0%
6 - 9	12.0%
10 - 19	9.0%
20 - 49	7.0%
50 or more	5.0%

A separate corporate limit is not available for solo practitioners. The minimum premium for separate limits for partnerships, corporations or professional associations is $1,000.

III. PARTNERSHIP–CORPORATION-PROFESSIONAL ASSOCIATION EXTENDED REPORTING ENDORSEMENT COVERAGE

Partnerships, corporations, or professional associations that purchase a separate limit of liability may be eligible to purchase an Extended Reporting Endorsement upon cancellation of the coverage. For the entity to be eligible for the separate limit extended reporting endorsement, all physician members insured on the policy must exercise their right to purchase an individual extended reporting endorsement. The premium charge for the entity extended reporting endorsement will be a percentage of the sum of each member physician's net individual reporting endorsement premium, based on the number of insureds and the table in Paragraph II, above.

IV. CLAIMS FREE CREDIT PROGRAM

A physician will be considered claims free for purposes of this credit program if:

1. no loss payment has been made during the Evaluation Period, and
2. the total of allocated loss adjustment expense [ALAE] payments made during the Evaluation Period plus any Company established reserves for loss or ALAE does not exceed $35,000.

Only claims reported during the Evaluation Period shall be included in measuring the payment and reserve criteria stated above. The Evaluation Period is based upon the physician's rating class as defined in the table below and shall end on the effective date of the policy period to be rated. The Evaluation Period shall begin no earlier than the time when the physician first begins the practice of medicine following formal training (residency or a continuous period of residency and fellowships). The Company will review the claims history of each insured or applicant for the purpose of evaluating the applicability of each claim based upon the facts and circumstances of specific claims. Reported incidents that do not involve a demand for damages by a third party will not be included in the evaluation.

Class	Evaluation Period
1 – 4	10 Yrs.
5 – 9	7 Yrs.
10 – 15	5 Yrs.

The claims free physician will receive a 3% credit for compliance with the minimum Claims Free Period and will earn an additional 1% credit for each continuous claims free year thereafter up to 15% in total. However, if the physician has been continuously insured by the Company for 10 or more years, the maximum allowable Claims Free Credit that can be earned will be increased to 20%.

Credits will be applied or removed at policy inception or renewal only. Inclusion of claims history with prior carriers is subject to presentation of information acceptable to the Company. The determination of claims to be included and payment or reserve amounts to be considered will be based upon information available at the time the policy is rated, typically 60 days prior to effective date.

Notwithstanding any other provisions of this section, no insured with 3 or more claims will be eligible for a claims free credit without management approval.

V. LEGAL DEFENSE COVERAGE

The Company offers two levels of Professional Legal Defense Coverage to insured physicians. No charge is made for the basic coverage. The most comprehensive entails a base premium charge of $500 per insured physician. A volume discount will be given, per the schedule below.

# of Insured Physicians	Discount %
5 and under	0%
6 through 10	5%
11 through 20	10%
over 20	15%

Limits of Liability will be offered as follows:

# of insureds	"Each Covered Investigation"	"Each Policy Period"
1 – 5	$25,000	$ 25,000 x (# of insureds)
6 – 10	$25,000	$125,000
11 – 20	$25,000	$175,000
21 +	$25,000	$225,000

The limit of liability for "covered audits" will be $5,000 per covered insured with a deductible of $1,000 per audit per insured.

SECTION 6

PHYSICIAN EXTENDER, PARAMEDICAL AND

ALLIED HEALTH PROFESSIONAL LIABILITY RATING

I. PHYSICIAN EXTENDER, AND PARAMEDICAL EMPLOYEES, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY

Professional employees (other than cytotechnologists, dentists, emergency medical technicians, certified registered nurse anesthetists, nurse midwives, nurse practitioners, optometrists, perfusionists, physicians, physicians' assistants, psychologists, surgeons or surgeons' assistants) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to Physician Class Codes 80420, 80151, 80153, 80266 or 80114, as specified, for the applicable claims-made year and limits of liability:

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

Employee	(Factors based on 80420)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Physician's Assistant (PA)	0.132	0.400	0.120
Surgeon's Assistant (SA)	0.132	0.400	0.120
Certified Nurse Practitioner (CNP)	0.132	0.400	0.120
Psychologist	0.040	0.111	0.033
Emergency Medical Technician (EMT)	0.004	0.010	0.003
Perfusionist	0.165	0.496	0.148

Employee	(Factors based on 80151)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	0.350	0.105
CRNA employed by an insured group - separate limits basis	N/A	0.250	0.075
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	0.150	N/A	N/A
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	0.075	N/A	N/A

For CRNAs employed by an insured performing pain management procedures, apply the above factor to the 80475(C) ISO code and applicable rate class.

(If the ratio of employed CRNA's to Anesthesiologists exceeds 4-to-1, the Company may decline to insure the risk, or apply an additional premium, at its sole discretion.)

Employee	(Factors based on 80153)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Midwife (CNM)	0.116	0.350	0.105

Employee	(Factors based on 80266)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Cytotechnologist	0.100	N/A	N/A

Employee	(Factors based on 80114)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Optometrist	0.025	0.050	0.015

NOTE: When the limits of liability apply on a shared basis with the physicians of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of physicians carry.

II. ALLIED HEALTH PROFESSIONAL EMPLOYEES

Certain Allied Health professionals are eligible for separate insurance by the Company at individual limits of liability. The premium charge will be determined by applying the factors below to the appropriate rate for the designated Physician Class Code in the applicable rating territory.

SPECIALTY	CLASS CODE	$1M/$3M
		(Factors based on 80420)
Audiologist	80760	0.018
Cardiac Technician	80751	0.025
Casting Technician	80752	0.020
Certified Nurse Practitioner	80964	0.400
Clinical Nurse Specialist	80964	0.400
Counselor	80712	0.045
Dietitian	89761	0.018
EKG Technician	80763	0.018
Medical Assistant	80762	0.018
Medical Lab Technician	80711	0.018
Nurse	80998	0.018
Nurse - Student	82998	0.005
Nurse, RN Perform X-Ray Therapy	80714	0.018
Occupational Therapist	80750	0.025
O.R. Technician	80758	0.125
Ophthalmic Assistant	80755	0.018
Orthopedic Technician	80756	0.020
Perfusionist	80764	0.500
Pharmacist	59112	0.025
Phlebotomist	80753	0.018
Physical Therapist (Emp)	80945	0.025
Physical Therapist (Ind)	80946	0.090
Physical Therapy Aide	80995	0.018
Physiotherapist	80938	0.018
Psychologist	80912	0.111
Pump Technician	88888	0.020
Respiratory Therapist	80601	0.122
Social Worker	80911	0.045
Sonographer	80754	0.018
X-Ray/Radiologic Technician	80713	0.018
X-Ray Therapy Technician	80716	0.025
		(Factors based on 80211)
Dental Assistant	80207	0.100
Dental Hygienist	80208	0.100
		(Factors based on 80114)
Optometrist (Optical)	80944	0.032
Optometrist (Employee*)	80944	**See note below
Optometrist (Independent**)	80944	**See note below

*25% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)
**75% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)

At the discretion of the underwriter, additional insured status may be granted to the non-insured allied health entity for a 10% additional charge. The entity will share in the limits of liability of the insured allied health provider but only for the activities of such provider.

Reporting Endorsements are available to Allied Health Professionals insured under separate policies by application of the factors below.

Prior Year Claims-Made	Factors
1	1.00
2	1.25
3+	1.50

STEP-RATING FACTORS

First Year	50% of mature premium
Second Year	80% of mature premium
Third Year	100% of mature premium

Mature premiums under $500 are not eligible for the step-rating factors.

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SECTION 7

STATE RATES AND EXCEPTIONS – PHYSICIANS, SURGEONS AND PODIATRISTS

I. RATES

A. Rating Classes - Illinois

The following indicates the classification codes that are applicable to the rating classes on the following pages:

Rating Class	Industry Class Codes					
1	80102(A)	80179	80235	80240	80256(A)	
	80178	80231	80236	80254	80265	
2	80233	80249	80256(B)	80267	80620	
	80238	80252	80263	80474		
3	80102(B)	80222(A)	80255	80266	80289	80473
	80145(A)	80244	80257	80268	80420	80621
	80151	80245	80260	80282	80431	
4	80114	80222(B)	80246	80261	80421(A)	
	80145(B)	80241	80253	80269		
5	80145(C)	80280	80286	80291	80360	80424(F)
	80274	80283	80287	80293	80421(B)	
	80278	80284	80288	80294	80425	
6	80115	80167	80281(A)	80472		
	80159	80277	80421(C)			
7	80102(C)	80117(A)	80281(B)	80475(A)		
8	80117(B)					
9	80117(C)	80143	80154(A)	80155	80156	80169
10	80146	80150				
11	80154(B)	80171	80475(B)			
12	80144	80153				
13	80475(C)	80476				
14	80152	80475(D)				
15	Not used at this time.					

B. Physicians and Surgeons Professional Liability Rates

1. Claims-Made Rates by Year

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	4,611	7,801	9,927	10,990	12,054
2	6,206	10,990	14,180	15,775	17,369
3	7,801	14,180	18,433	20,559	22,685
4	9,396	17,369	22,685	25,343	28,001
5	10,990	20,559	26,938	30,128	33,317
6	12,904	24,386	32,041	35,869	39,696
7	14,180	26,938	35,444	39,696	43,949
8	16,795	32,169	42,418	47,542	52,667
9	20,559	39,696	52,454	58,833	65,212
10	23,749	46,075	60,960	68,402	75,844
11	26,938	52,454	69,465	77,971	86,476
12	30,128	58,833	77,971	87,539	97,108
13	33,317	65,212	86,476	97,108	107,740
14	42,886	84,350	111,992	125,814	139,635
15	46,075	90,729	120,498	135,382	150,267

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	3,654	5,887	7,376	8,120	8,864
2	4,771	8,120	10,352	11,469	12,585
3	5,887	10,352	13,329	14,818	16,306
4	7,003	12,585	16,306	18,167	20,027
5	8,120	14,818	19,283	21,516	23,749
6	9,459	17,497	22,855	25,535	28,214
7	10,352	19,283	25,237	28,214	31,191
8	12,183	22,945	30,119	33,706	37,293
9	14,818	28,214	37,145	41,610	46,075
10	17,051	32,679	43,098	48,308	53,518
11	19,283	37,145	49,052	55,006	60,960
12	21,516	41,610	55,006	61,704	68,402
13	23,749	46,075	60,960	68,402	75,844
14	30,447	59,471	78,821	88,496	98,171
15	32,679	63,937	84,775	95,194	105,613

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	3,208	4,994	6,185	6,780	7,376
2	4,101	6,780	8,566	9,459	10,352
3	4,994	8,566	10,948	12,139	13,329
4	5,887	10,352	13,329	14,818	16,306
5	6,780	12,139	15,711	17,497	19,283
6	7,852	14,282	18,569	20,712	22,855
7	8,566	15,711	20,474	22,855	25,237
8	10,031	18,640	24,380	27,249	30,119
9	12,139	22,855	30,000	33,572	37,145
10	13,925	26,428	34,763	38,931	43,098
11	15,711	30,000	39,526	44,289	49,052
12	17,497	33,572	44,289	49,648	55,006
13	19,283	37,145	49,052	55,006	60,960
14	24,642	47,861	63,341	71,081	78,821
15	26,428	51,434	68,104	76,440	84,775

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	4,133	6,844	8,651	9,555	10,459
2	5,488	9,555	12,266	13,622	14,977
3	6,844	12,266	15,881	17,688	19,496
4	8,200	14,977	19,496	21,755	24,014
5	9,555	17,688	23,111	25,822	28,533
6	11,182	20,942	27,448	30,702	33,955
7	12,266	23,111	30,340	33,955	37,570
8	14,489	27,557	36,269	40,624	44,980
9	17,688	33,955	44,799	50,222	55,644
10	20,400	39,377	52,029	58,355	64,681
11	23,111	44,799	59,259	66,488	73,718
12	25,822	50,222	66,488	74,622	82,755
13	28,533	55,644	73,718	82,755	91,792
14	36,666	71,911	95,407	107,155	118,903
15	39,377	77,333	102,636	115,288	127,940

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
1	4,292	7,163	9,077	10,034	10,990
2	5,728	10,034	12,904	14,339	15,775
3	7,163	12,904	16,732	18,645	20,559
4	8,598	15,775	20,559	22,951	25,343
5	10,034	18,645	24,386	27,257	30,128
6	11,756	22,090	28,979	32,424	35,869
7	12,904	24,386	32,041	35,869	39,696
8	15,258	29,094	38,318	42,930	47,542
9	18,645	35,869	47,351	53,092	58,833
10	21,516	41,610	55,006	61,704	68,402
11	24,386	47,351	62,661	70,316	77,971
12	27,257	53,092	70,316	78,927	87,539
13	30,128	58,833	77,971	87,539	97,108
14	38,739	76,057	100,935	113,374	125,814
15	41,610	81,798	108,590	121,986	135,382

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	5,985	10,548	13,590	15,111	16,633
2	8,267	15,111	19,675	21,956	24,238
3	10,548	19,675	25,759	28,801	31,843
4	12,830	24,238	31,843	35,646	39,449
5	15,111	28,801	37,928	42,491	47,054
6	17,849	34,277	45,229	50,705	56,180
7	19,675	37,928	50,096	56,180	62,265
8	23,416	45,411	60,074	67,406	74,737
9	28,801	56,180	74,433	83,560	92,686
10	33,364	65,307	86,602	97,249	107,897
11	37,928	74,433	98,770	110,939	123,108
12	42,491	83,560	110,939	124,629	138,318
13	47,054	92,686	123,108	138,318	153,529
14	60,744	120,065	159,613	179,387	199,161
15	65,307	129,192	171,782	193,077	214,372

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	4,616	7,810	9,940	11,005	12,069
2	6,213	11,005	14,199	15,796	17,393
3	7,810	14,199	18,458	20,587	22,717
4	9,407	17,393	22,717	25,379	28,041
5	11,005	20,587	26,976	30,170	33,364
6	12,921	24,420	32,087	35,920	39,753
7	14,199	26,976	35,494	39,753	44,012
8	16,818	32,214	42,479	47,611	52,743
9	20,587	39,753	52,530	58,918	65,307
10	23,782	46,141	61,048	68,501	75,954
11	26,976	52,530	69,566	78,084	86,602
12	30,170	58,918	78,084	87,667	97,249
13	33,364	65,307	86,602	97,249	107,897
14	42,947	84,472	112,156	125,998	139,839
15	46,141	90,861	120,674	135,580	150,487

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	3,977	6,533	8,236	9,088	9,940
2	5,255	9,088	11,643	12,921	14,199
3	6,533	11,643	15,051	16,754	18,458
4	7,810	14,199	18,458	20,587	22,717
5	9,088	16,754	21,865	24,420	26,976
6	10,621	19,821	25,954	29,020	32,087
7	11,643	21,865	28,679	32,087	35,494
8	13,739	26,056	34,267	38,373	42,479
9	16,754	32,087	42,308	47,419	52,530
10	19,310	37,197	49,123	55,085	61,048
11	21,865	42,308	55,937	62,751	69,566
12	24,420	47,419	62,751	70,418	78,084
13	26,976	52,530	69,566	78,084	86,602
14	34,642	67,862	90,009	101,082	112,156
15	37,197	72,973	96,823	108,749	120,674

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	5,301	9,179	11,765	13,058	14,351
2	7,240	13,058	16,937	18,876	20,815
3	9,179	16,937	22,108	24,694	27,280
4	11,119	20,815	27,280	30,512	33,745
5	13,058	24,694	32,452	36,330	40,209
6	15,385	29,349	38,658	43,312	47,967
7	16,937	32,452	42,795	47,967	53,138
8	20,117	38,813	51,276	57,508	63,740
9	24,694	47,967	63,482	71,239	78,996
10	28,573	55,724	73,825	82,875	91,926
11	32,452	63,482	84,168	94,511	104,855
12	36,330	71,239	94,511	106,148	117,784
13	40,209	78,996	104,855	117,784	130,713
14	51,845	102,269	135,885	152,692	169,500
15	55,724	110,026	146,228	164,329	182,429

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
1	5,529	9,636	12,374	13,742	15,111
2	7,582	13,742	17,849	19,903	21,956
3	9,636	17,849	23,325	26,063	28,801
4	11,689	21,956	28,801	32,224	35,646
5	13,742	26,063	34,277	38,384	42,491
6	16,207	30,991	40,848	45,776	50,705
7	17,849	34,277	45,229	50,705	56,180
8	21,217	41,012	54,209	60,807	67,406
9	26,063	50,705	67,132	75,346	83,560
10	30,170	58,918	78,084	87,667	97,249
11	34,277	67,132	89,036	99,987	110,939
12	38,384	75,346	99,987	112,308	124,629
13	42,491	83,560	110,939	124,629	138,318
14	54,811	108,201	143,794	161,591	179,387
15	58,918	116,415	154,746	173,911	193,077

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	7,317	13,213	17,143	19,109	21,074
2	10,265	19,109	25,004	27,952	30,900
3	13,213	25,004	32,865	36,796	40,726
4	16,161	30,900	40,726	45,639	50,552
5	19,109	36,796	48,587	54,482	60,378
6	22,646	43,870	58,020	65,095	72,169
7	25,004	48,587	64,309	72,169	80,030
8	29,839	58,256	77,200	86,673	96,145
9	36,796	72,169	95,752	107,543	119,334
10	42,691	83,961	111,474	125,230	138,986
11	48,587	95,752	127,195	142,917	158,639
12	54,482	107,543	142,917	160,604	178,291
13	60,378	119,334	158,639	178,291	197,943
14	78,065	154,708	205,804	231,351	256,899
15	83,961	166,499	221,525	249,038	276,551

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	5,549	9,676	12,427	13,803	15,178
2	7,612	13,803	17,930	19,993	22,056
3	9,676	17,930	23,432	26,183	28,935
4	11,739	22,056	28,935	32,374	35,813
5	13,803	26,183	34,437	38,564	42,691
6	16,279	31,136	41,040	45,993	50,945
7	17,930	34,437	45,442	50,945	56,448
8	21,314	41,205	54,467	61,097	67,728
9	26,183	50,945	67,453	75,707	83,961
10	30,310	59,199	78,458	88,088	97,717
11	34,437	67,453	89,463	100,468	111,474
12	38,564	75,707	100,468	112,849	125,230
13	42,691	83,961	111,474	125,230	138,986
14	55,072	108,722	144,489	162,372	180,256
15	59,199	116,976	155,494	174,753	194,012

1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	4,723	8,025	10,226	11,326	12,427
2	6,374	11,326	14,628	16,279	17,930
3	8,025	14,628	19,030	21,231	23,432
4	9,676	17,930	23,432	26,183	28,935
5	11,326	21,231	27,834	31,136	34,437
6	13,307	25,193	33,117	37,079	41,040
7	14,628	27,834	36,638	41,040	45,442
8	17,335	33,249	43,858	49,162	54,467
9	21,231	41,040	54,247	60,850	67,453
10	24,533	47,644	63,051	70,754	78,458
11	27,834	54,247	71,855	80,659	89,463
12	31,136	60,850	80,659	90,564	100,468
13	34,437	67,453	89,463	100,468	111,474
14	44,342	87,262	115,876	130,182	144,489
15	47,644	93,865	124,680	140,087	155,494

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	6,433	11,444	14,785	16,456	18,126
2	8,939	16,456	21,467	23,973	26,478
3	11,444	21,467	28,149	31,490	34,830
4	13,950	26,478	34,830	39,006	43,182
5	16,456	31,490	41,512	46,523	51,535
6	19,462	37,503	49,530	55,544	61,557
7	21,467	41,512	54,875	61,557	68,239
8	25,576	49,731	65,834	73,885	81,936
9	31,490	61,557	81,602	91,625	101,647
10	36,501	71,580	94,966	106,659	118,352
11	41,512	81,602	108,329	121,693	135,056
12	46,523	91,625	121,693	136,726	151,760
13	51,535	101,647	135,056	151,760	168,465
14	66,568	131,715	175,146	196,862	218,577
15	71,580	141,738	188,510	211,896	235,282

1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
1	6,728	12,034	15,571	17,340	19,109
2	9,381	17,340	22,646	25,299	27,952
3	12,034	22,646	29,721	33,258	36,796
4	14,687	27,952	36,796	41,217	45,639
5	17,340	33,258	43,870	49,176	54,482
6	20,524	39,625	52,360	58,727	65,095
7	22,646	43,870	58,020	65,095	72,169
8	26,997	52,572	69,622	78,148	86,673
9	33,258	65,095	86,319	96,931	107,543
10	38,564	75,707	100,468	112,849	125,230
11	43,870	86,319	114,618	128,767	142,917
12	49,176	96,931	128,767	144,686	160,604
13	54,482	107,543	142,917	160,604	178,291
14	70,401	139,380	185,365	208,358	231,351
15	75,707	149,992	199,515	224,277	249,038

2. Extended Reporting Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors
By Month

Claims-Made
Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

C. Excess Limits Premium Factors

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate. Excess limits are only offered above underlying limits of $1,000,000.

Factors for limits above $1 Million/$3 Million Primary:

	$1M/$3M Primary	
EXCESS LIMITS	Classes 1 – 8	Classes 9 – 15
$1M	0.1977	0.2535
$2M	0.3164	0.4040
$3M	0.4055	0.5169
$4M	0.4723	0.6016
$5M	0.5324	0.6779

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.

D. Replacement Coverage Factors for Insurance of Unreported Claims on Previously-Issued Reporting Endorsements or Occurrence Coverage

Apply the appropriate factor from the tables below to the insured's mature rate for 1M/3M limits.

1. Factors for Indefinite Reporting Endorsement

a) All Specialties other than OB/GYN, Pediatrics or Anesthesiology

Prior Occurrence Coverage Expiration Date or Prior Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.840	1.380	1.680	1.860	1.980	2.040
1+ to 2 yrs. ago	0.540	0.840	1.020	1.140	1.200	1.200
2+ to 3 yrs. ago	0.300	0.480	0.600	0.660	0.660	0.660
3+ to 4 yrs. ago	0.180	0.300	0.360	0.360	0.360	0.360
4+ to 5 yrs. ago	0.120	0.180	0.180	0.180	0.180	0.180
5+ to 6 yrs. ago	0.060	0.060	0.060	0.060	0.060	0.060
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

b) Anesthesiologist Specialty

Prior Occurrence Coverage Expiration Date or Prior Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.600	0.900	1.080	1.140	1.164	1.176
1+ to 2 yrs. ago	0.300	0.480	0.540	0.564	0.576	0.576
2+ to 3 yrs. ago	0.180	0.240	0.264	0.276	0.276	0.276
3+ to 4 yrs. ago	0.060	0.084	0.096	0.096	0.096	0.096
4+ to 5 yrs. ago	0.024	0.036	0.036	0.036	0.036	0.036
5+ to 6 yrs. ago	0.012	0.012	0.012	0.012	0.012	0.012
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

c) OB/GYN and Pediatric Specialties

Prior Occurrence Coverage Expiration Date or Prior Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year
Up to 1 yr. ago	0.720	1.260	1.620	1.800	1.920	2.016
1+ to 2 yrs. ago	0.540	0.900	1.080	1.200	1.296	1.368
2+ to 3 yrs. ago	0.360	0.540	0.660	0.756	0.828	0.876
3+ to 4 yrs. ago	0.180	0.300	0.396	0.468	0.516	0.552
4+ to 5 yrs. ago	0.120	0.216	0.288	0.336	0.372	0.396
5+ to 6 yrs. ago	0.096	0.168	0.216	0.252	0.276	0.288
6+ to 7 yrs. ago	0.072	0.120	0.156	0.180	0.192	0.192
7+ to 8 yrs. ago	0.048	0.084	0.108	0.120	0.120	0.120
8+ to 9 yrs. ago	0.036	0.060	0.072	0.072	0.072	0.072
9+ to 10 yrs. ago	0.024	0.036	0.036	0.036	0.036	0.036
10+ to 11 yrs. ago	0.012	0.012	0.012	0.012	0.012	0.012
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

	7th Year	8th Year	9th Year	10th Year	11th Year+
Up to 1 yr. ago	2.088	2.136	2.172	2.196	2.208
1+ to 2 yrs. ago	1.416	1.452	1.476	1.488	1.488
2+ to 3 yrs. ago	0.912	0.936	0.948	0.948	0.948
3+ to 4 yrs. ago	0.576	0.588	0.588	0.588	0.588
4+ to 5 yrs. ago	0.408	0.408	0.408	0.408	0.408
5+ to 6 yrs. ago	0.288	0.288	0.288	0.288	0.288
6+ to 7 yrs. ago	0.192	0.192	0.192	0.192	0.192
7+ to 8 yrs. ago	0.120	0.120	0.120	0.120	0.120
8+ to 9 yrs. ago	0.072	0.072	0.072	0.072	0.072
9+ to 10 yrs. ago	0.036	0.036	0.036	0.036	0.036
10+ to 11 yrs. ago	0.012	0.012	0.012	0.012	0.012
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

2. Factors for Annually Renewed Prior Occurrence and Tail Replacement Coverage

This option is intended to allow the policyholder the choice of a shorter reporting period at a lesser premium than charged for the indefinite period and an effectively longer payment plan than otherwise offered. It is not intended to allow the Company the option to refuse to extend the reporting period at any given year. If the insured elects to renew a sufficient number of times (seven for OB/GYN and Pediatrics and four for all other specialties), this coverage will convert from an annually renewing reporting period to an indefinite reporting period.

a) All Specialties other than OB/GYN, Pediatrics or Anesthesiology

Occurrence Coverage End Date or	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.275	0.495	0.605	0.660	0.715	0.770
1+ to 2 yrs. ago	0.220	0.330	0.385	0.440	0.495	0.495
2+ to 3 yrs. ago	0.110	0.165	0.220	0.275	0.275	0.275
3+ to 4 yrs. ago	0.055	0.110	0.165	0.165	0.165	0.165
4+ to 5 yrs. ago	0.055	0.110	0.110	0.110	0.110	0.110
5+ to 6 yrs. ago	0.055	0.055	0.055	0.055	0.055	0.055
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

b) Anesthesiologist Specialty

Occurrence Coverage End Date or	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.275	0.385	0.495	0.528	0.539	0.550
1+ to 2 yrs. ago	0.110	0.220	0.253	0.264	0.275	0.275
2+ to 3 yrs. ago	0.110	0.143	0.154	0.165	0.165	0.165
3+ to 4 yrs. ago	0.033	0.044	0.055	0.055	0.055	0.055
4+ to 5 yrs. ago	0.011	0.022	0.022	0.022	0.022	0.022
5+ to 6 yrs. ago	0.011	0.011	0.011	0.011	0.011	0.011
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

c) OB/GYN and Pediatric Specialties

Occurrence Coverage End Date or Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year
Up to 1 yr. ago	0.165	0.330	0.495	0.550	0.572	0.594
1+ to 2 yrs. ago	0.165	0.330	0.385	0.407	0.429	0.451
2+ to 3 yrs. ago	0.165	0.220	0.242	0.264	0.286	0.297
3+ to 4 yrs. ago	0.055	0.077	0.099	0.121	0.132	0.143
4+ to 5 yrs. ago	0.022	0.044	0.066	0.077	0.088	0.099
5+ to 6 yrs. ago	0.022	0.044	0.055	0.066	0.077	0.088
6+ to 7 yrs. ago	0.022	0.033	0.044	0.055	0.066	0.066
7+ to 8 yrs. ago	0.011	0.022	0.033	0.044	0.044	0.044
8+ to 9 yrs. ago	0.011	0.022	0.033	0.033	0.033	0.033
9+ to 10 yrs. ago	0.011	0.022	0.022	0.022	0.022	0.022
10+ to 11 yrs. ago	0.011	0.011	0.011	0.011	0.011	0.011
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

	7th Year	8th Year	9th Year	10th Year	11th Year+
Up to 1 yr. ago	0.616	0.627	0.638	0.649	0.660
1+ to 2 yrs. ago	0.462	0.473	0.484	0.495	0.495
2+ to 3 yrs. ago	0.308	0.319	0.330	0.330	0.330
3+ to 4 yrs. ago	0.154	0.165	0.165	0.165	0.165
4+ to 5 yrs. ago	0.110	0.110	0.110	0.110	0.110
5+ to 6 yrs. ago	0.088	0.088	0.088	0.088	0.088
6+ to 7 yrs. ago	0.066	0.066	0.066	0.066	0.066
7+ to 8 yrs. ago	0.044	0.044	0.044	0.044	0.044
8+ to 9 yrs. ago	0.033	0.033	0.033	0.033	0.033
9+ to 10 yrs. ago	0.022	0.022	0.022	0.022	0.022
10+ to 11 yrs. ago	0.011	0.011	0.011	0.011	0.011
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

3. Group Discount Factor

After calculating each insured's preliminary rate for the Replacement Coverage, apply the factor from the table below which corresponds to the number of insureds in the group for whom the coverage is purchased.

# of Physicians	Discount Factor
1	1.000
2-3	0.970
4-6	0.950
7-10	0.925
11-20	0.900
Over 20	0.850

II. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

1. Section 2, Physicians & Surgeons Specialty Codes and Descriptions, is amended by adding the following:

	Industry Class Code		
Specialty	No Surgery	Minor Surgery	Major Surgery
Endocrinology	80238	-	-
Infectious Disease	80246		-

2. Section 2, Physicians & Surgeons Specialty Codes and Descriptions, is amended by adding the following:

CLARIFICATION OF SPECIALTY CODES

Code	Specialty Description
80102(A)	Emergency Medicine – Moonlighting - no surgery
80102(B)	Emergency Medicine – Moonlighting - minor surgery
80102(C)	Emergency Medicine – clinic/hosp. primarily
80117(A)	Family/General Practice, No OB – major surgery
80117(B)	Family/General Practice, Limited OB – major surgery
80117(C)	Family/General Practice, Significant OB – major surgery
80145(A)	Urology – no surgery
80145(B)	Urology – minor surgery
80145(C)	Urology – major surgery
80154(A)	Orthopedic (No Spines) – major surgery
80154(B)	Orthopedic (Spines) – major surgery
80222(A)	Hospitalist – Hosp. Employed/ Single Hospital Affiliation
80222(B)	Hospitalist – Non-Hosp. Employed/Multiple Hospital Affiliations
80256(A)	Dermatology – no surgery
80256(B)	Dermatology – no surgery (specified procedures)
80281(A)	Cardiovascular Dis. – minor surgery
80281(B)	Cardiovascular Dis. – minor surgery, specified procedures
80421(A)	FP or GP – assist in major surgery - own patients only (no minor)
80421(B)	FP or GP – minor surgery & assist in major surgery- own patients
80421(C)	FP or GP – assist in major surgery
80424(F)	Urgent Care – no surgery
80424(V)	Urgent Care – no surgery, rated on a per-visit basis
80475(A)	Pain Management – no major surgery
80475(B)	Pain Management – basic procedures
80475(C)	Pain Management – intermediate procedures
80475(D)	Pain Management – advanced procedures
80116(A)	Physician Assistant
80116(B)	Surgeon Assistant
80960(D)	Nurse Anesthetist – Dental
80960(M)	Nurse Anesthetist – Medical

3. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),
plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

This method is applied in a similar manner if more than one practice change occurred during the previous four years. The components are pro-rated if the change occurred at a date other than the policy anniversary date.

4. Item X, Rate Change Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.

5. Item V, Scheduled Rating Program, of Section 4, Professional Liability Discounts, is amended as follows:

V. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by physicians and surgeons engaged in the practice of medicine. Exposure conditions vary with respect to:

	Debit/Credit
1. Number of years experience in medicine;	+/- 10%
2. Number of patient exposures;	+/- 10%
3. Organization (if any) and size;	+/- 10%
4. Medical standards review and claims review committees;	+/- 10%
5. Other risk management practices and procedures;	+/- 10%
6. Training, accreditation and credentialing;	+/- 10%
7. Continuing Medical Education activities;	+/- 10%
8. Professional liability claim experience;	+/- 10%
9. Record-keeping practices;	+/- 10%
10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;	+/- 10%
11. Participation in capitation contracts; and*	+ 10%
12. Insured group maintains differing limits of liability on members.*	+ 10%

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more physicians as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

* NOTE: No credit will be given for #11 or #12 above.

6. Item VI, Deductibles, of Section 4, Professional Liability Discounts, is hereby replaced by the following:

VI. DEDUCTIBLES

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer ($1M/$3M). Deductibles are subject to approval by the company based on financial statements to be submitted by the insured and financial guarantees as required. The amount of the deductible credit may never exceed 80% of the annual aggregate, if any. In the event where the credit exceeds 80% of the aggregate, the annual aggregate will be adjusted accordingly. This Rule does not apply to any risk when a deductible has been added for underwriting reasons.

A. Individual Deductibles

Discount as a Percentage of Rate for Applicable Primary Limit

These per claim and aggregate (if any) deductibles apply to each insured separately.

INDEMNITY ONLY Deductible Per Claim		INDEMNITY AND ALAE Deductible Per Claim	
$ 5,000	2.5%	$ 5,000	6.5%
$10,000	4.5%	$10,000	11.5%
$15,000	6.0%	$15,000	15.0%
$20,000	8.0%	$20,000	17.5%
$25,000	9.0%	$25,000	20.0%
$50,000	15.0%	$50,000	30.5%
$100,000	25.0%	$100,000	44.5%
$200,000	37.5%	$200,000	55.0%
$250,000	42.0%	$250,000	58.0%
Per Claim/Aggregate		**Per Claim/Aggregate**	
$ 5,000/15,000	2.0%	$ 5,000/15,000	5.5%
$10,000/30,000	4.0%	$10,000/30,000	10.5%
$25,000/75,000	8.5%	$25,000/75,000	19.0%
$50,000/150,000	14.0%	$50,000/150,000	29.5%
$100,000/300,000	24.0%	$100,000/300,000	43.0%
$200,000/600,000	36.0%	$200,000/600,000	53.5%
$250,000/750,000	40.0%	$250,000/750,000	56.5%

For other deductible amounts selected by policyholders, refer to management for rating.

B. Group Deductibles

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

Group aggregate deductible discounts apply to $1M/$3M premiums only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate ($000)	Number of Insureds 2 - 19	20 - 40	41 - 60	61 - 100	Maximum Credit
5/15	.020	.018	.015	.012	$ 10,500
10/30	.038	.035	.030	.024	21,000
25/75	.084	.079	.070	.058	52,500
50/150	.145	.139	.127	.109	105,000
100/300	.234	.228	.216	.196	210,000
200/600	.348	.346	.338	.321	420,000
250/750	.385	.385	.381	.368	525,000

Indemnity & ALAE Deductible Per Claim/Aggregate ($000)	Number of Insureds 2 - 19	20 - 40	41 - 60	61 - 100	Maximum Credit
5/15	.029	.026	.021	.017	$ 12,750
10/30	.068	.063	.054	.043	25,500
25/75	.119	.112	.099	.082	63,750
50/150	.186	.179	.163	.140	127,500
100/300	.258	.252	.239	.216	255,000
200/600	.396	.394	.385	.366	510,000
250/750	.467	.467	.462	.446	637,500

7. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

VIII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

8. Section 5, Additional Practice Charges, is hereby amended as follows:

V. LEGAL DEFENSE COVERAGE

The Company offers two levels of Professional Legal Defense Coverage to insured physicians. No charge is made for the basic coverage, form PRA-HCP-070. The most comprehensive, form PRA-HCP-071, entails a base premium charge of $100 per insured physician. A volume discount will be given, per the schedule below.

# of Insured Physicians	Discount %
5 and under	0%
6 through 10	5%
11 through 20	10%
over 20	15%

Limits of Liability will be offered as follows:

# of insureds	"Each Covered Investigation"	"Each Policy Period"
1 - 5	$25,000	$25,000 X (# of insureds)
6 - 10	$25,000	$125,000
11 - 20	$25,000	$175,000
21 +	$25,000	$225,000

The limit of liability for "covered audits" will be $5,000 per covered insured with a deductible of $1,000 per audit per insured.

III. STATE REQUIREMENTS

A. Policy Issuance

1. The Illinois State Law Endorsement must be attached to the policy at the time of issuance.

2. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

III. QUARTERLY INSTALLMENT OPTIONS

1. Quarterly Installment Option One
   a. A minimum initial deposit required, which shall be 40 percent of the estimated total premium due at policy inception;
   b. The remaining premium spread equally among the second, third and fourth installments at 20 percent of the estimated total premium, and due 3, 6 and 9 months from policy inception, respectively;
   c. No interest or installment charges;
   d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
   e. The installment plan will be limited to insureds whose premium exceeds $500.00 per year.

2. Quarterly Installment Option Two – (35/25/25/15)
   a. A minimum initial deposit required, which shall be 35 percent of the estimated total premium due at policy inception;
   b. The remaining premium will be 25 percent for the second and third installments and 15 percent for the fourth installment, and due 3, 6 and 9 months from policy inception, respectively;
   c. No interest or installment charges;
   d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
   e. The installment plan will be limited to insureds whose premium exceeds $500.00 per year.

B. Rules

1. Item I, Rates and Premium Calculations, of Section 1, Introduction, is hereby amended.

   A. Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being $500 (not applicable to paramedicals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3., VIII, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the policy effective date. Subject to Section 3, VIII, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.

2. Item IX, Reporting Endorsements, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby amended.

With respect to calculation of Reporting Endorsement premium, the only credits/discounts that apply are the Part-Time discount and Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. With respect to risks or exposures written on a consent-to-rate basis, (a) rated basis or Full-Time Equivalent Rating basis at the time the Reporting Endorsement is issued, Reporting Endorsement premium will be calculated on that same basis. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

CorpCare™

SECTION 8

STATE RATES AND EXCEPTIONS – GROUPS

I. RATES

A. Per Patient Rates – Emergency Room / Urgent Care

1. Rating of Emergency Room and Urgent Care Groups may, at the Company's option be rated on a per 100 patient visit basis. A risk with fewer than 10,000 patient encounters each year will not qualify for this rating method.

2. For risks rated on a per patient basis, develop premium using the following per100 patient visit rates. The above rates are subject to increased limit factors and standard CorpCare™ rating factors.

Claims-made Rate Per 100 Patient Visits $1,000,000 / $3,000,000						
Class	**Code**	**Territory 1**	**Territory 2**	**Territory 3**	**Territory 4**	**Territory 5**
Emergency Room	80429	$2,287	$1,613	$1,298	$1,950	$2,062
Urgent Care	80424(V)	$1,725	$1,220	$984	$1,472	$1,557

3. Extended Reporting Endorsement Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors
By Month

Claims-Made Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

Reporting Endorsement ("Tail") Premium Development

a. Determine the tail premium for each current scheduled health care provider, if applicable. See Section 9, State Rates and Exceptions - Physicians, Surgeons and Podiatrists - Extended Reporting Period Endorsement (Tail Coverage). The only credits/discounts that apply are the Part-Time discount and Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

b. For per patient rated risks, use average number of patient visits for the previous thirty-six months. The only credit/discount that applies is the Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.
c. Determine the remaining optional separate limit premium, if applicable.
d. Add premiums determined in Steps a., b. and c. to determine total policy premium.

B. Rating Territories

Territory	County
1	Cook, Madison, St. Clair and Will Counties
2	Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson, Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties
3	Remainder of State
4	DuPage, Kane, Lake and McHenry Counties
5	Jackson and Vermilion Counties

II. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

1. Item X, Rate Change Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.

2. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

   The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

   1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

   2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

   For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

   Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),
   plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

   This method is applied in a similar manner if more than one practice change occurred during the previous four years. The components are pro-rated if the change occurred at a date other than the policy anniversary date.

3. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

VIII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

III. STATE REQUIREMENTS

A. Policy Issuance

1. The Illinois State Law Endorsement must be attached to the policy at the time of issuance.

2. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

III. QUARTERLY INSTALLMENT OPTIONS

1. Quarterly Installment Option One – (40/20/20/20)
   a. A minimum initial deposit required, which shall be 40 percent of the estimated total premium due at policy inception;
   b. The remaining premium spread equally among the second, third and fourth installments at 20 percent of the estimated total premium, and due 3, 6 and 9 months from policy inception, respectively;
   c. No interest or installment charges;
   d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
   e. The installment plan will be limited to insureds whose premium exceeds $500.00 per year.

2. Quarterly Installment Option Two – (35/25/25/15)
   a. A minimum initial deposit required, which shall be 35 percent of the estimated total premium due at policy inception;
   b. The remaining premium will be 25 percent for the second and third installments and 15 percent for the fourth installment, and due 3, 6 and 9 months from policy inception, respectively;
   c. No interest or installment charges;
   d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
   e. The installment plan will be limited to insureds whose premium exceeds $500.00 per year.

B. Rules

SECTION 9

STATE RATES AND EXCEPTIONS – PHYSICIAN EXTENDER, PARAMEDICAL

AND

ALLIED HEALTH PROFESSIONAL LIABILITY RATING

I. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

1. Item X, Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.

2. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),
plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

This method is applied in a similar manner if more than one practice change occurred during the previous four years. The components are pro-rated if the change occurred at a date other than the policy anniversary date.

3. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

VIII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

4. Item I of Section 6, Physician Extender, Paramedical and Allied Health Professional Liability Rating, is hereby amended as follows:

I. PHYSICIAN EXTENDER, AND PARAMEDICAL EMPLOYEES, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY

Professional employees (other than cytotechnologists, dentists, emergency medical technicians, certified registered nurse anesthetists, nurse midwives, nurse practitioners, optometrists, perfusionists, physicians, physicians' assistants, psychologists, surgeons or surgeons' assistants) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to Physician Class Codes 80420, 80151, 80153, 80266 or 80114, as specified, for the applicable claims-made year and limits of liability.

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

Employee	(Factors based on 80420)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Physician's Assistant (PA)	0.027	0.083	0.025
Surgeon's Assistant (SA)	0.041	0.124	0.037
Certified Nurse Practitioner (CNP)	0.045	0.138	0.041
Psychologist	0.040	0.050	0.015
Emergency Medical Technician (EMT)	0.004	0.010	0.003
Perfusionist	0.166	0.500	0.149

Employee	(Factors based on 80151)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	0.420	0.126
CRNA employed by an insured group - separate limits basis	N/A	0.300	0.090
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	0.180	N/A	N/A
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	0.090	N/A	N/A

For CRNAs employed by an insured performing pain management procedures, apply the above factor to the 80475(C) ISO code and applicable rate class.

(If the ratio of employed CRNA's to Anesthesiologists exceeds 4-to-1, the Company may decline to insure the risk, or apply an additional premium, at its sole discretion.)

Employee	(Factors based on 80153)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Midwife (CNM)	0.129	0.388	0.116

Employee	(Factors based on 80266)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Cytotechnologist	0.100	N/A	N/A

Employee	(Factors based on 80114)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Optometrist	0.020	0.040	0.012

NOTE: When the limits of liability apply on a shared basis with the physicians of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of physicians carry.

5. Item II of Section 6, Physician Extender, Paramedical and Allied Health Professional Liability Rating, is hereby amended as follows:

II. ALLIED HEALTH PROFESSIONAL EMPLOYEES

Certain Allied Health professionals are eligible for separate insurance by the Company at individual limits of liability. The premium charge will be determined by applying the factors below to the appropriate rate for the designated Physician Class Code in the applicable rating territory.

SPECIALTY	CLASS CODE	$1M/$3M
		(Factors based on 80420)
Audiologist	80760	0.018
Cardiac Technician	80751	0.025
Casting Technician	80752	0.020
Certified Nurse Practitioner	80964	0.138
Clinical Nurse Specialist	80964	0.400
Counselor	80712	0.045
Dietitian	89761	0.018
EKG Technician	80763	0.018
Medical Assistant	80762	0.018
Medical Lab Technician	80711	0.018
Nurse	80998	0.018
Nurse – Student	82998	0.005
Nurse, RN Perform X-Ray Therapy	80714	0.018
Occupational Therapist	80750	0.025
O.R. Technician	80758	0.125
Ophthalmic Assistant	80755	0.018
Orthopedic Technician	80756	0.020
Perfusionist	80764	0.500
Pharmacist	59112	0.025
Phlebotomist	80753	0.018
Physical Therapist (Emp)	80945	0.025
Physical Therapist (Ind)	80946	0.090
Physical Therapy Aide	80995	0.018
Physician Assistant	80116(A)	0.083
Physiotherapist	80938	0.018
Psychologist	80912	0.050
Pump Technician	88888	0.020
Respiratory Therapist	80601	0.025
Social Worker	80911	0.045
Sonographer	80754	0.018
Surgeon Assistant	80116(B)	0.124
X-Ray/Radiologic Technician	80713	0.018
X-Ray Therapy Technician	80716	0.025
		(Factors based on 80211)
Dental Assistant	80207	0.100
Dental Hygienist	80208	0.100
Nurse Anesthetist – Dental	80960(D)	4.306

SPECIALTY	CLASS CODE	$1M/$3M
		(Factors based on 80151)
Nurse Anesthetist – Medical	80960(M)	0.420
		(Factors based on 80114)
Optometrist (Optical)	80944	0.032
Optometrist (Employee*)	80944	**See note below
Optometrist (Independent**)	80944	**See note below

*25% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)
**75% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)

Health Care Professional NOC	80301	Refer to Company

At the discretion of the underwriter, additional insured status may be granted to the non-insured allied health entity for a 10% additional charge. The entity will share in the limits of liability of the insured allied health provider but only for the activities of such provider.

C. Extended Reporting Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors
By Month

Claims-Made Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

II. STATE REQUIREMENTS

A. Policy Issuance

1. The Illinois State Law Endorsement must be attached to the policy at the time of issuance.

2. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

III. QUARTERLY INSTALLMENT OPTIONS

1. Quarterly Installment Option One – (40/20/20/20)
   a. A minimum initial deposit required, which shall be 40 percent of the estimated total premium due at policy inception;
   b. The remaining premium spread equally among the second, third and fourth installments at 20 percent of the estimated total premium, and due 3, 6 and 9 months from policy inception, respectively;
   c. No interest or installment charges;
   d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
   e. The installment plan will be limited to insureds whose premium exceeds $500.00 per year.

2. Quarterly Installment Option Two – (35/25/25/15)
   a. A minimum initial deposit required, which shall be 35 percent of the estimated total premium due at policy inception;
   b. The remaining premium will be 25 percent for the second and third installments and 15 percent for the fourth installment, and due 3, 6 and 9 months from policy inception, respectively;
   c. No interest or installment charges;
   d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
   e. The installment plan will be limited to insureds whose premium exceeds $500.00 per year.

B. Rules